

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05325

Reg. Dist. No. 290

1. PLACE OF DEATH:

County TalbotCity or town Easton
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 13 1/2 hours

Hospital, institution, or street address where death occurred:

The Memorial Hospital - Easton, md.How long in hospital or institution? 13 1/2 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County TalbotCity or town Chappe
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Bessie Bailey

3. (b) Social Security Number

4. Sex

Female

5. Color or race

Colored

6.(a) Single, married, widowed, or divorced

Widow

6.(b) Name of husband or wife _____

7. Birth date of

deceased (mo., day, yr.)

July 10, 1888

6.(c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

581112

hrs.

min.

9. Birthplace

Talbot Co.
(Town, county, and state)

10. Usual occupation

H. W.

11. Industry or business _____

FATHER

12. Name

Unknown

13. Birthplace

Unknown

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Address

Memorial Hospital
Easton md.
Bureau

17.

(Burial, cremation, or removal, Which?)

Date thereof

6/26/47
(month) (day) (year)

Cemetery or crematory

Locallon

18. Funeral director

Address

Trappe md
Lewis H. Bayne
Cambridge md

19.

(Date rec'd by registrar)

19 47N.H. Neuman
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22 19 47 at 5:15 PM M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 _____, to 19 _____

and that I last saw h. _____ alive on 19 _____

Immediate cause of death

Stroke

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of June 22-1947Where did injury occur? Chappe Talbot md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Auto accident

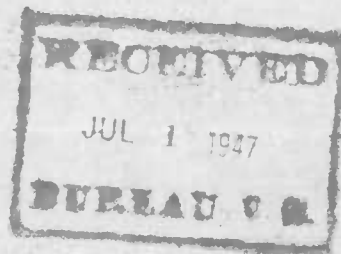
Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed 6-23-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

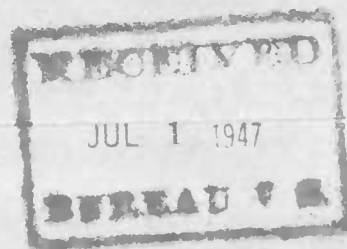
186a

JB

05326

Reg. Dist. No. 290

1. PLACE OF DEATH: County... <u>Talbot</u> City or town... <u>Easton Md.</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?... <u>43 days</u> Hospital, institution, or street address where death occurred: <u>Memorial Hospital</u> How long in hospital or institution?... <u>Easton - 43 days</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State... <u>Delaware</u> County... City or town... <u>Saferd</u> (If outside city or town limits, write RURAL and give nearest town) Street No... <u>107 Cannon Street</u> (If rural, give LOCATION) 2.(a) If veteran, name war... <input checked="" type="checkbox"/>			
3. (a) FULL NAME <u>Mrs. Eva Broughman</u>				3. (b) Social Security Number			
4. Sex <u>Female</u>		5. Color or race <u>White</u>		6. (a) Single, married, widowed, or divorced <u>married</u>			
6. (b) Name of husband or wife ... <u>Charles F Broughman</u>							
7. Birth date of deceased (mo., day, yr.) ... <u>5/30/173</u>							
8. AGE: Years... <u>74 1/2</u> yrs.		Months... <u>22</u>		Days... <u>22</u>		It less than one day... <u>hrs.</u> <u>min.</u>	
9. Birthplace ... <u>Clyde N. Y.</u> (Town, county, and state)							
10. Usual occupation ... <u>Housewife</u>							
11. Industry or business							
FATHER	12. Name ... <u>Larvin Van Dyke</u>						
	13. Birthplace ... <u>Clyde N. Y.</u>						
MOTHER	14. Maiden name ... <u>Leahella Wood</u>						
	15. Birthplace ... <u>England</u>						
16. Informant ... <u>Jane B. Jones</u> Address... <u>Easton Md</u>							
17. (Burial, cremation, or removal. Which?) ... <u>Burial</u> Date thereof... <u>June 24 1977</u> (month) (day) (year) Cemetery or crematory... <u>Springfield</u> Location... <u>Easton Md</u>							
18. Funeral director ... <u>James E. Leonard & Son</u> Address... <u>Easton Md</u>							
19. (Date rec'd by registrar) ... <u>6/23</u> <u>47</u> <u>N.H. Neirin</u> Registrar							
MEDICAL CERTIFICATION							
20. DATE OF DEATH ... <u>6-22-</u> <u>19</u> <u>47</u> at <u>3</u> <u>50</u> <u>P.</u> <u>M.</u>							
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>9 hrs</u> <u>19</u> <u>47</u> to <u>22 June</u> <u>19</u> <u>47</u> and that I last saw him alive on <u>22 June</u> <u>19</u> <u>47</u>							
Immediate cause of death ... <u>Pneumonia</u> DURATION ... <u>7 days</u>							
Due to ...							
Due to ...							
Other conditions ... <u>Fractured hip - left</u> (Include pregnancy within 8 months of death)							
Major findings of operations ...							
Autopsy results ...							
PHYSICIAN: Please underline the cause to which death should be charged statistically.							
22. VIOLENCE: If death was due to external causes, fill in the following: <u>Accident</u> Date of... <u>25 June 47</u> Accident, suicide, or homicide... <u>Accident</u> Date of... <u>25 June 47</u> Where did injury occur?... <u>Saferd</u> (County) <u>Delaware</u> (State) Injured at home, farm, industry, public place (where?)... <u>home</u> Means of injury... <u>free</u> injured at work?							
23. SIGNATURE ... <u>Theresa Harrison M.D.</u> M. D. or other Address... <u>Easton Maryland</u> Date signed... <u>27 June 47</u>							



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05327

Reg. Dist. No. 292

1. PLACE OF DEATH: *Talbot*
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State.....*Ind* County.....*Talbot*
 City or town.....*Propper outside*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2(a) If veteran, name war.....

3. (a) FULL NAME *Joseph Brown*

3. (b) Social Security Number

4. Sex *Male* 5. Color or race *col* 6. (a) Single, married, widowed, or divorced *widowed*
 6. (b) Name of husband or wife *Rosetta Brown*

7. Birth date of deceased (mo., day, yr.) *Aug 17, 1875* 6. (c) If alive, give age..... years

8. AGE: Years *71* Months *10* Days *4* If less than one day..... hrs. min.

9. Birthplace *Talbot Co Ind.*
 (Town, county, and state)

10. Usual occupation *farm laborer*

11. Industry or business *farm*

12. Name *James Brown*

13. Birthplace *North Carolina?*

14. Maiden name *Margaret*

15. Birthplace *Henry Brown*

16. Informant *Maple Ind. RD*

17. (Burial, cremation, or removal. Which?) *Burial* Date thereof *June 27, 1947*
 (month) (day) (year)

Cemetery or crematory *Scott A.M.E. Co.*

Location *Propper (rural)*

18. Funeral director *Leura H. Baynes*

Address *Cambridge*

19. *June 27, 1947* (Date rec'd by registrar) *Joseph Brown* Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *June 27, 1947* at *1 A.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19..... to..... 19.....
 and that I last saw him..... alive on..... 19.....

Immediate cause of death *Disintegration*
 Due to *Auto accident*
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)

DURATION

Normal

Major findings of operations..... Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
 Accident, suicide, or homicide *Accident* Date of *6-27-47*
 Where did injury occur? *in Propper Ind* (City or town) (State)
 Injured at home, farm, industry, public place (where?) *in way*
 Means of injury *Auto accident* Injured at work? *No*

23. SIGNATURE *Louis J. Harty M.D.*
 Address *Easton Ind* Date signed *6-27-47*

MARYLAND STATE DEPARTMENT OF HEALTH

1015 H. CHURCH ST. BALTIMORE

CERTIFICATE OF DEATH

1. DATE OF DEATH

2. TIME OF DEATH

3. PLACE OF DEATH

4. CAUSE OF DEATH

5. MANNER OF DEATH

6. AGENT OF DEATH

7. SEX

8. AGE

9. RACE

10. BIRTH DATE

11. BIRTH PLACE

12. BIRTH TIME

13. BIRTH WEIGHT

14. BIRTH LENGTH

15. BIRTH HEAD CIRCUMFERENCE

16. BIRTH SKIN COLOR

17. BIRTH HAIR COLOR

18. BIRTH EYE COLOR

19. BIRTH MOUTH COLOR

20. BIRTH NOSE COLOR

21. BIRTH EAR COLOR

22. BIRTH FINGER COLOR

23. BIRTH TOE COLOR

24. BIRTH HEEL COLOR

25. BIRTH PALM COLOR

26. BIRTH SOLE COLOR

27. BIRTH NAIL COLOR

28. BIRTH SKIN CONDITION

29. BIRTH SKIN TEMPERATURE

30. BIRTH SKIN PULSE

31. BIRTH SKIN RESPIRATION

32. BIRTH SKIN SWEAT

33. BIRTH SKIN SECRETION

34. BIRTH SKIN EXCRETION

35. BIRTH SKIN ABSORPTION

36. BIRTH SKIN REFLECTION

37. BIRTH SKIN TRANSMISSION

38. BIRTH SKIN CONDUCTION

39. BIRTH SKIN INSULATION

40. BIRTH SKIN PROTECTION

41. BIRTH SKIN DEFENSE

42. BIRTH SKIN REPAIR

43. BIRTH SKIN GROWTH

44. BIRTH SKIN DEVELOPMENT

45. BIRTH SKIN MATURATION

46. BIRTH SKIN AGING

47. BIRTH SKIN DEGENERATION

48. BIRTH SKIN DEATH

49. BIRTH SKIN REBIRTH

50. BIRTH SKIN RESURRECTION

RECEIVED
JUN 27 1947
BUREAU 7 6

RECEIVED BY THE BUREAU OF VITAL RECORDS

1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

05329

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County TalbotCity or town Easton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Samuel Green

4. Sex

F

5. Color or race

B

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

Levin Camper

7. Birth date of

deceased (mo., day, yr.)

12/27/92

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

55

hrs.

min.

9. Birthplace

md.
(Town, county, and state)

10. Usual occupation

H. W.

11. Industry or business

FATHER
MOTHER

12. Name

Samuel Green

13. Birthplace

Trappe, Md

14. Maiden name

Levin Camper

15. Birthplace

Trappe, Md

16. Informant

Levin Camper

Address

husband

17.

(Burial, cremation, or removal, Which?)

Date thereof

6/18/47
(month) (day) (year)

Cemetery or crematory

Trappe, Md

Location

Trappe, Md.

18. Funeral director

William H. Bannister

Address

Cambridge, Va

19.

(Date rec'd by registrar)

19

47W. L. Norris
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty Talbot

City or town

Easton

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

6/151947

at

10:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19.....

to

19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death

Cerebral hemorrhage

DURATION

3 hrs

Due to

Essential hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Levin Camper, MD
M. D. or other

Address

Easton, Md

Date signed

6-16-47

RECEIVED

JUN 21 1947

BUREAU V A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH: County <u>Baltimore</u> City or town <u>East</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? Hospital, institution, or street address where death occurred: How long in hospital or institution?				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>md</u> County <u>Harford</u> City or town <u>East New Market</u> (If outside city or town limits, write RURAL and give nearest town) Street No. _____ (If rural, give LOCATION) 2.(a) If veteran, name war _____			
3. (a) FULL NAME <u>Ellis Webster Charles</u>				3. (b) Social Security Number			
4. Sex <u>Female</u>		5. Color or race <u>white</u>		6. (a) Single, married, widowed, or divorced <u>Widow</u>		MEDICAL CERTIFICATION	
6. (b) Name of husband or wife				20. DATE OF DEATH <u>3 June</u> 19 <u>47</u> , at <u>5:00 a.m.</u>			
7. Birth date of deceased (mo., day, yr.) <u>April 18th 1862</u>				21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>Apr</u> 19 <u>46</u> to <u>3 June</u> 19 <u>47</u> and that I last saw <u>her</u> alive on <u>20 May</u> 19 <u>47</u>			
8. AGE: Years <u>85</u> Months <u>1</u> Days _____ If less than one day _____ hrs. _____ min.		6. (c) If alive, give age _____ years		Immediate cause of death <u>Bronchopneumonia</u>			
9. Birthplace <u>md</u> (Town, county, and state)				DURATION <u>7 days</u>			
10. Usual occupation <u>Home work</u>				Due to _____			
11. Industry or business				Due to _____			
12. Name <u>James R. Webster</u>				Other conditions <u>Anterior chest wall</u>			
13. Birthplace <u>md</u>				(Include pregnancy within 3 months of death)			
14. Maiden name <u>Lucy A. Parkes</u>				Major findings of operations _____			
15. Birthplace <u>md</u>				Date of op. _____			
16. Informant <u>Mrs. Spence Phillips</u>				Autopsy results _____			
Address <u>Burlock</u>				PHYSICIAN: Please underline the cause to which death should be charged statistically.			
17. Burial (Burial, cremation, or removal, which?) <u>Burial</u> Date thereof <u>June 5 1947</u> (month) (day) (year)				22. VIOLENCE: If death was due to external causes, fill in the following:			
Cemetery or crematory <u>Burlock</u>				Accident, suicide, or homicide _____ Date of _____			
Location <u>East New Market</u>				Where did injury occur? _____ (City or town) _____ (County) _____ (State)			
18. Funeral director <u>H. B. Wilcox</u>				Injured at home, farm, industry, public place (where?) _____			
Address <u>Burlock</u>				Means of injury _____ Injured at work? _____			
19. 6/3-47 (Date rec'd by registrar) 19 <u>47</u> <u>N. S. Burns</u> Registrar				23. SIGNATURE <u>Thos. M. Harrison</u> M. D. or other _____ Address <u>East</u> Date signed <u>4 June 47</u>			

Mr. Nathan F. Jones

RECEIVED

JUN 17 1947

BUREAU 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05331

161a

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County TalbotCity or town Easton (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County TalbotCity or town Easton (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Ronald Lee Conrad

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Infant

6.(b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

June 4, 1947

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

18 hrs.

min.

9. Birthplace

Easton, Talbot Co. Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19

476/51947N. H. Meier

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4 19 47 at 5 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 47, to 19 47and that I last saw him alive on 19 47

Immediate cause of death

Compensated aortic stenosis

DURATION

Due to

Due to

Other conditions

Multiparity

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Leona M. M. D. M. D. M. D.

M. D. or other

Address Easton Md. Date signed 6/5/47

RECEIVED

JUN 9 1947

BUREAU 78

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

05332

CERTIFICATE OF DEATH

Reg. Dist. No. 292

1. PLACE OF DEATH:

County Harbor
 City or town Trappe Md
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Harbor
 City or town Trappe (rural)
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Rosa v Green

3. (b) Social Security Number

4. Sex

Female

5. Color or race

Col

6. (a) Single, married, widowed, or _____

Widow

6. (b) Name of husband or wife

Daniel Green

6. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

Nov. 28 1878

8. AGE:

Years

Months

Days

It less than one day

687✓

hrs.

min.

9. Birthplace

Baltimore, Md.
(Town, county, and state)

10. Usual occupation

House work

11. Industry or business

FATHER

12. Name

Thomas Smith

13. Birthplace

Md

MOTHER

14. Maiden name

Irene Hoffmann

15. Birthplace

Trappe, Md.

16. Informant

Irene Hoffmann

Address

Trappe Md

17. (Burial, cremation, or removal, which?)

Burial

Date thereof

June 4 1947
(month) (day) (year)

Cemetery or crematory

Scottdale Cemetery

Location

Trappe, Md.

18. Funeral director

Levin H. Payne

Address

Cambridge, Md.

19. (Date rec'd by registrar)

June 30 1947

Registrar

Dr. J. H. Payne

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 241947, at 7 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 15 1947, to June 24 1947and that I last saw him alive on June 15 1947

Immediate cause of death

Coronary occlusion

DURATION

1 day

Due to

Arterio Sclerosis

Due to

?

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

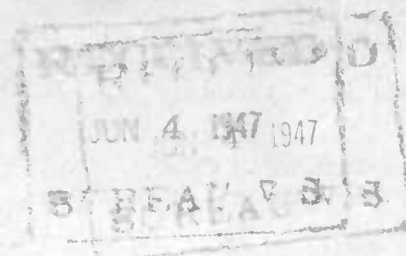
23. SIGNATURE

William S. Symmes

M. D. or other

Address

TrappeDate signed June 24 1947



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97

05333

CERTIFICATE OF DEATH

Reg. Dist. No. 240

1. PLACE OF DEATH:

County SalbotCity or town Easton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or other address where death occurred:

E. Dover St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SalbotCity or town Easton
(If outside city or town limits, write RURAL and give nearest town)Street No. E. Dover St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Joseph George Triffin

3. (b) Social Security Number

4. Sex Male 5. Color of race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Esther L. Young6. (c) If alive, give age 47 years7. Birth date of deceased (mo., day, yr.) January 2, 18628. AGE: Years 85 Months 5 Days 26 If less than one day

hrs. min.

9. Birthplace East Co. Delaware
(City, town, county, and state)10. Usual occupation Retired

11. Industry or business

12. Name John R. Triffin13. Birthplace Delaware14. Maiden name Packard, George15. Birthplace Delaware16. Informant Mr. J. H. BartholomewAddress Easton, Md.17. Burial, cremation, or removal. Which? Burial Date thereon June 30, 1947
(month) (day) (year)Cemetery or crematory EastonLocation Easton, Md.18. Funeral director W. Ellis ClarkAddress Easton, Md.19. 6/30 47 N.B. Neer
(Date reg'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 19 47, at 1 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 19 47, to 6/28/1947and that I last saw him alive on 6/27/1947

Immediate cause of death

DURATION

Arteriosclerosis, generalized

Due to

Due to

Other conditions Modern

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

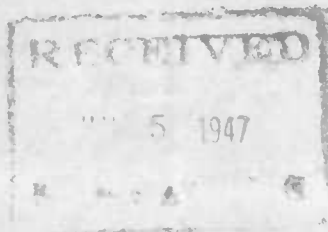
Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Ellis Clark M. D. or otherAddress Easton, Md. Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05334

Reg. Dist. No. 290

1. PLACE OF DEATH:

County Subs.
 City or town Newtown, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 months
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Talbot
 City or town Newtown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Rural
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Norman Lee Harris

3. (b) Social Security Number

4. Sex M. 5. Color or race C. 6. (a) Single, married, widowed, or divorced N.

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) March 23 1947 6. (c) If alive, give age _____ years

8. AGE: Years 3 Months 1 Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Newtown, Talbot, Md.
 (Town, county, and state)

10. Usual occupation Infant

11. Industry or business

FATHER 12. Name William Cooper
 13. Birthplace Md.

MOTHER 14. Maiden name May Harris
 15. Birthplace Md.

16. Informant Louis Harris
 Address Newtown, Md.

17. Burial Date thereof June 16 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Frederick
 Location Rural Section

18. Funeral director Chas. L. Lark
 Address Chesapeake

19. 6/16 47 N.L. Harris
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14 19 47 at 6 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 13 19 47 to June 14 19 47 and that I last saw him alive on June 13 19 47

Immediate cause of death Bronchopneumonia

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE Ken C. Edwards M.D.

Address Chesapeake Date signed 6/16



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County Talbot Co.
 City or town Easton, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 15 hrs.
 Hospital, institution or street address where death occurred:
Easton Memorial Hospital
 How long in hospital or institution? 15 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Caroline
 City or town Federalburg, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war. _____

3. (a) FULL NAME

John Henry Hollander

3. (b) Social Security Number

4. Sex Male 5. Color or race negro 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife Frances Hollander
 6.(c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) 2/29/18

8. AGE: Years 66 Months 3 Days 24 If less than one day _____ hrs. _____ min.

9. Birthplace Federalburg, Md.
 (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Cannery

12. Name Romas M. Hollander

13. Birthplace Anderson, Caroline Co. Md.

14. Maiden name Frances E. Shepherd

15. Birthplace Caroline Co. Md.

16. Informant Frances Hollander

Address Federalburg, Md.

17. Burial Date thereof 6/26/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Federal Hill

Location Federalburg, Md.

18. Funeral director J. J. Trampton, Son.

Address Federalburg, Md.

19. 6/24 19 47 Rob. Reeves
 (Date reg'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 19 47 at 3:05 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-22 19 47 to 6-23 19 47

and that I last saw him alive on _____ 19 _____

Immediate cause of death _____ DURATION _____

Shock 6 hours

Due to Second + third degree burns 15 hrs

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date 6/23/47

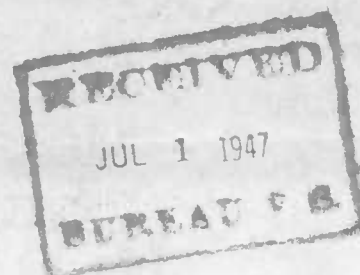
Where did injury occur? Federalburg, Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Burns Injured at work? no

23. SIGNATURE J. T. B. Ambler. M. D. or other _____

Address Easton Date signed _____



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05336

Reg. Dist. No. 290

1. PLACE OF DEATH:

County Talbot
 City or town Easton
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Memorial HospitalHow long in hospital or institution? 7 days

3. (a) FULL NAME

Kilmer, George

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Edith Kilmer

7. Birth date of

deceased (mo., day, yr.)

Sept 28, 1882

8. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

64 45 78 7821 hrs. min.

9. Birthplace

Kilmer, Kansas
(Town, county, and state)

10. Usual occupation

Comptroller, Texaco Oil Co

11. Industry or business

Texaco Oil Co.

FATHER

MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

19. 47

N.H. Nevins

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CarolineCity or town Easton
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 19 June 19 47 at 12:59A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

13 June 19 47, to 19 June 19 47
and that I last saw him alive on 19 June 19 47

Immediate cause of death

① Atherosclerosis lung rt
② (Post op)
③ Pneumonia lobes rt

Due to.....

Due to.....

Due to.....

Other conditions Choleliths death② Choleliths (Include principal within 3 months of death) ParMajor findings of operations CholelithsPassport Date of op. 6/14/47Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. D. H. H. H. M. D. or otherAddress Easton, Md Date signed 6/23/47

RECEIVED

JUN 27 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:
 County... Talbot
 City or town... Easton, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 days
 Hospital, institution, or street address where death occurred:
Memorial Hospital
 How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State... Maryland County... Queen Anne
 City or town... Chesler, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION) ✓
 2.(a) If veteran, name war.....

3. (a) FULL NAME
Margaret King

3. (b) Social Security Number

4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife James King
 7. Birth date of deceased (mo., day, yr.) 1915 6. (c) If alive, give age years
 8. AGE: Years 32 Months Days If less than one day hrs. min.

9. Birthplace Unk
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name William Calvert

13. Birthplace "Western Shore," Md.

14. Maiden name Williamson

15. Birthplace "

16. Informant James King

Address Chesler, Md.

17. (Burial, cremation, or removal. Which?) Burial Date thereof 6/22/47
 (month) (day) (year)

Cemetery or crematory Wynside, Md.

Location Wynside, Md.

18. Funeral director James A. Henry

Address 222 Cedar St. Cambridge, Md.

19. 6/20 19 47 N.H. Newby
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-19- 19 47 at 1 40 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 15 June to 19 June 19 47
 and that I last saw him alive on 15 June 19 47

Immediate cause of death Brain abscess, pneumonia, & internal

It was admitted to hospital recently with pt. pneumonia suddenly became ill. He was discharged from the vagina and passed a few fetid stools. He was long ill due to respiratory failure secondary to infection, shock and blood loss.

Other conditions Abortion, spontaneous

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of

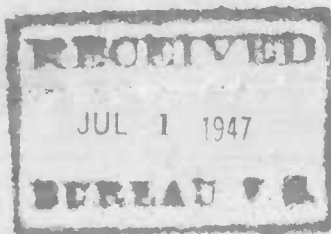
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James A. Henry M. D. or other

Address Chesler, Maryland Date signed 24 June 47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05338

Reg. Dist. No. 290

1. PLACE OF DEATH:

County Talbot
 City or town Easton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 1/2 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Talbot
 City or town Easton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Exempt for 4 1/2 years Queen Anne Co.
 (If rural, give LOCATION)
 2.(a) If veteran, name war no

3. (a) FULL NAME

Henry Mc Clement

3. (b) Social Security Number

none

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

B. (b) Name of husband or wife

Annie Bishop McClement

7. Birth date of deceased (mo., day, yr.)

July - 11 - 1862

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

85328

.....hrs.

.....min.

9. Birthplace

Queen Anne Co. Maryland
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

(Retired)

FATHER

12. Name

Henry Mc Clement

13. Birthplace

Delaware

MOTHER

14. Maiden name

Martha Lounsburg

15. Birthplace

Delaware

16. Informant

Lola Mc Clement

Address

514 Goldsboro St. Easton, Md

17.

(Burial, cremation, or removal, which?)

Date thereof

June 11 - 47
(month) (day) (year)

Cemetery or crematory

Centerville

Location

Centerville Maryland

18. Funeral director

Barton Bros

Address

Centerville, Maryland

19.

(Date read by registrar)

6/947R. H. News

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 8th 1947, at 7 P. M.

I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1st 1947 to June 8th 1947and that I last saw him alive on June 1st 1947

Immediate cause of death

DURATION

Chronic Valvulardisorders of the heart

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. B. McArthur

M. D. or other

Address

Centerville, MdDate signed 6/9/47

RECEIVED
JUN 17 1947
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05339

Reg. Diat. No. 291

1. PLACE OF DEATH:

County TalbotCity or town St. Michaels
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Five years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County TalbotCity or town St. Michaels
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Noah Asbury Moore

3. (b) Social Security Number

212-12-3243

4. Sex

Male

5. Color or race

Black

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Mary Moore6. (c) If alive, give age 63 years7. Birth date of deceased (mo., day, yr.) January 26, 18848. AGE: Years Months Days If less than one day
63 5 24 hrs. min.9. Birthplace Wetipquin, Maryland.
(Town, county, and State)10. Usual occupation Laborer

11. Industry or business

12. Name John Moore13. Birthplace Wetipquin, Maryland.14. Maiden name Mary E. Wilson15. Birthplace Quantico, Virginia.16. Informant Arletta HorseyAddress McDaniel, Maryland.17. Burial. Date thereof June 26, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Sherwood CemeteryLocation Sherwood, Maryland.18. Funeral director J. Norman MarshallAddress St. Michaels, Maryland.19. 6/26 47 Mrs. Robt. L. Seth
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 19 47 at 11:00 P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 23 19 47 to June 23 19 47 and that I last saw him alive on June 23 19 47Immediate cause of death Uremia

DURATION

5 daysDue to Pyelonephritis

Due to

Other conditions Pneumonia (Hypostatic) 24 hrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Adm. J. Mitchell, M.D. M. D. or otherAddress St. Michaels, Md. Date signed 6-24-47

100-11-112

RECEIVED
JUN 27 1947
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 299

1. PLACE OF DEATH:

County Talbot
 City or town Edston Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 25 min
 Hospital, institution, or street address where death occurred:
Memorial Hospital
 How long in hospital or institution? 25 min

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Talbot
 City or town Edston
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Wansor Street
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Nellie O'Brien

3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

James O'Brien

7. Birth date of deceased (mo., day, yr.)

Feb. 20 1873

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

74

4

1

hrs.

min.

9. Birthplace

Baltimore Md

(Town, county, and state)

10. Usual occupation

Rooming House Operator

11. Industry or business

MOTHER FATHER

12. Name

Unknown

13. Birthplace

Unknown

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Mrs H. Sherman Bailey Jr.

Address

327 West Lorraine Ave. Baltimore

17. (Burial, cremation, or removal. Which?)

Burial

Date thereof

June 23, 1947

Cemetery or crematory

Cemetery

Location

Heavitt, Md

18. Funeral director

Reverend Newman Harrison

Address

St. Michael, Md.

19.

6/22 47

(Date rec'd by registrar)

N. H. Newman

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

6-21-

19 47, at 12 50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 46, 1947, to June 21, 1947

and that I last saw him alive on June 21, 1947

Immediate cause of death

Intra-cranial Hemorrhage

DURATION

24 hrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Walter F. Beckett

M. D. or other

Address

Edston Md

Date signed 7-8-47

RECEIVED
JUL 4 1947
BERRAN 783

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05341

Reg. Dist. No. 290

1. PLACE OF DEATH:

County... *Eastern*

City or town... *Rural Eastern*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *15 yrs*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... *MD* County... *Tackett*

City or town... *Rural Eastern*
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) NAME

Bessie Hughes Roberts

3.(b) Social Security Number

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

It less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

18. Informant

Address

17.

(Burial or removal. Which?)

Date thereof

Cemetery or place of

Location

16. Funeral director

Address

19.

(Date rec'd by Registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... *June 1* 19... *47* at... *M*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6-1 19... *47* to... *6-1* 19... *47*

and that I last saw him... *or* alive on... *6-1* 19... *47*

Immediate cause of death

Coronary Thrombosis

DURATION

1/2 hr.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. T. B. Amble
Eastern Md.

M. D. or other

Address... *6-2-47* Date signed

MARGIN RESERVED FOR BINDING

VS A15

information carefully. The correct age of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item is especially important. Physicians: please write the cause

RECEIVED

JUN 17 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05342

Reg. Dist. No. 290

1. PLACE OF DEATH:

City or town Talbot
Easton Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 47 days
 Hospital, institution, street address where death occurred:
Easton Memorial Hospital
 How long in hospital or institution? 47 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Talbot
 City or town Tilghman, MD
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Mrs. Hattie Scharch

3. (b) Social Security Number

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced M
 6.(b) Name of husband or wife Frances L. Scharch
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., d., y.) 1894

8. AGE: years 53 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Talbot Co.
 (Town, county, and state)
 10. MD.

11. Indus. _____

12. Name Robert J. Ridgway

13. Birthplace Virginia

14. Maiden name Ernest Sinclair

15. Birthplace Maryland

16. Informant Memorial Hospital

Address Easton, Md.

17. Buried Date thereof June 30 - 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Tilghman M.E.

Location Tilghman Md.

18. Funeral director D. H. McMichael

Address St. Michaels

Date rec'd by registrar 6/30 1947 Registrar R. H. Reeves

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 1947 at 8 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 14 1947 to June 28 1947
 and that I last saw him alive on June 28 1947

Immediate cause of death Carcinoma of Gall bladder DURATION 1 yr.

Due to _____

Due to _____

Other conditions Cholelithiasis 13

(Include pregnancy within 3 months of death)

Major findings of operations Adenocarcinoma of GB with metastases to liver & pancreas Date of op. 6/28/47

Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE M. D. Noble M. D. or other _____

Address Easton Md Date signed 6/30/47

RECEIVED

JUL 5 1947

BUREAU

05343

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 29

1. PLACE OF DEATH: *Talbot*
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State.....
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME *Jennypson Turner*

3. (b) Social Security Number

4. Sex *Male* 5. Color or race *Col.* 6. (a) Single, married, widowed, or divorced *single*
 6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) *about 1905* 6.(c) If alive, give age..... years

8. AGE: Years *42* Months *✓* Days *✓* If less than one day..... hrs. min.

9. Birthplace.....
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

17. (Burial, cremation, or removal. Which?) *Burial* Date thereof.....
 (month) (day) (year)

Cemetery or crematory.....
 Location.....

18. Funeral director.....
 Address.....

19. (Date rec'd by registrar) *June 26 1947* Registrar.....

MEDICAL CERTIFICATION

20. DATE OF DEATH..... *June 22* 19... *47* at *4 A*..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19....., to..... 19.....
 and that I last saw him..... alive on..... 19.....

Immediate cause of death.....
Auto accident

Due to.....
 Due to.....

Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of *6-22-47*
 Where did injury occur?.....
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....
 Means of injury *Auto accident* Injured at work? *no*

23. SIGNATURE.....
 Address..... Date signed *6-23-47*

FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 27 1947
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 292

1. PLACE OF DEATH:

County TalbotCity or town Trappe rural
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County TalbotCity or town Trappe (rural)
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Noah Morris Wilson

3. (b) Social Security Number

4. Sex

Male

5. Color or race

Negro

6. (a) Single, married, widowed, or divorced

Widower

B. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

March 20 1876

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

7168

hrs.

min.

9. Birthplace

Trappe Talbot Co. Md
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Farmer

FATHER

12. Name

Albert Wilson
(rural)

13. Birthplace

Trappe Talbot Co. Md.

MOTHER

14. Maiden name

Henrietta Blake
(rural)

15. Birthplace

Trappe Talbot Co. Md

16. Informant

Norman Wilson

Address

Trappe Talbot Co. Md Rd

17.

(Burial, cremation, or removal Which?)

Date thereof

July 1, 1947
(month) (day) (year)

Cemetery or crematory

Trappe Cemetery

Location

Trappe Talbot Co. Md.

18. Funeral director

W. M. Sullivan & Son

Address

Cambridge Md.

19.

(Date rec'd by registrar)

1947

June 30June 30

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 19 47 at 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 2 19 46 to June 28 19 47and that I last saw him alive on June 28 19 47

Immediate cause of death

Chronic Endocarditis

DURATION

2 years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Hayward T. Webb M.D.
M. D. or other

Address

Easton, Md.Date signed 6/29/47

D. Ross

